

*****TESTIMONY IS EMBARGOED UNTIL 9:30 AM ON FRIDAY,
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**The Medicare Advantage Program and the
Role of Private Health Plans in Serving Medicare Beneficiaries**

by

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**for the
House Ways and Means Committee
Subcommittee on Health**

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I. Introduction

Chairman Herger, Ranking Member Stark, and members of the subcommittee, I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP). AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid.

Our members are strongly committed to continuing to offer high quality coverage options to meet the health care needs of Medicare beneficiaries, and we appreciate this opportunity to testify on the Medicare Advantage program.

Our plans have played an important role in serving Medicare beneficiaries. Currently, more than 13 millions seniors and people with disabilities have chosen to enroll in Medicare Advantage plans because they value the improved quality of care, additional benefits, and innovative services these plans provide. In addition, our community is working closely with policymakers to improve care for beneficiaries who are dually eligible for both Medicare and Medicaid, with the goal of ensuring that these individuals with special needs receive the preventive care they need, along with coordinated care for their multiple chronic conditions and the services and support that will allow them to stay in their homes if they wish and are able to do so.

Our testimony focuses on four broad topics:

- The leadership private plans are demonstrating in advancing delivery system reforms to improve quality and contain costs for Medicare beneficiaries;
- The value offered by private health plans participating in the Medicare Advantage program;
- The impact of the Affordable Care Act (ACA) on Medicare Advantage enrollees; and
- The need for congressional action to reauthorize Medicare Advantage Special Needs Plans (SNPs).

II. What Health Plans Are Contributing to Delivery System Reform

As policymakers consider how to sustain Medicare for generations to come, there are three areas where there is widespread agreement: (1) that health care costs are rising at unsustainable rates; (2) that doctors and hospitals should be paid for the effectiveness of the care they provide, rather than the volume of services they deliver; and (3) that more can and should be done to ensure that patients are receiving the right care in the right setting.

Private sector health plans – serving Medicare beneficiaries, as well as those under age 65 and enrollees in Medicaid – are demonstrating strong leadership in addressing these goals through innovative payment and delivery system reforms. These efforts are a critically important component of ensuring that our nation’s public safety net continues to protect patients and is sustainable in the long run.

While there is no magic bullet for reforming the payment system and bringing costs under control, health plans have developed a roadmap for the system-wide changes that are needed. Through a variety of partnerships with providers and other stakeholders, health plans are transforming the health care system and bringing the following tools and programs to Medicare Advantage enrollees:

- Helping patients navigate an increasingly complicated health care system through innovative care coordination programs;
- Changing how they pay for care through the introduction of prospective, risk-based payment systems;
- Working to change what we purchase by rewarding successful outcomes and high quality care to ensure that patients receive the right care at the right time in the right setting;
- Working with primary care physicians to expand patient-centered medical homes that promote care coordination and accountability for clinical outcomes;
- Linking payment changes to new benefit designs that provide information on high performing clinicians and hospitals and encourage patients to use them;

- Connecting clinicians with health plans' disease and case management services, embedding nurse case managers in provider practices, and offering clinical decision-support with the latest science and tools to inform the treatment decisions of providers;
- Offering intensive case management to help patients who are at high risk of hospitalization and providing them expanded access to urgent care centers, after-hours care and nurse help lines;
- Arranging for regular phone calls and in-home visits for patients discharged from the hospital to ensure that they keep their follow-up appointments, take their medications, and receive needed home care;
- Utilizing the latest technology to identify gaps in care, target potentially at-risk patients for support and intervention, and give physicians real-time data on how their patients are doing.

As a result of these efforts, health plans are now reporting tangible results in several key areas: improvements on quality metrics; reductions in unnecessary hospital admissions, readmissions, and emergency room visits; and reductions in health care cost growth. Building upon existing private sector initiatives, health plans also have developed important partnerships with the Centers for Medicare & Medicaid Services (CMS) in primary care, and are actively working to coordinate on comprehensive payment alternatives and to partner on standardizing performance metrics used in the private and public sectors.

Recognizing the importance of these public-private partnerships, our members appreciate that CMS has adopted an open process for collaborating and communicating with health plans to advance our shared goal of serving the best interests of Medicare beneficiaries.

III. The Value Offered by Health Plans Participating in the Medicare Advantage Program

Private health plans and insurers have a strong track record of offering high quality coverage options, with innovative programs and services to serve the Medicare population. In addition, plans are participating in innovative programs to meet the needs of dual eligibles and other beneficiaries with complex needs, using individualized care plans and care management, facilitating transitions between care settings, and employing other strategies to improve care and services for these vulnerable populations.

The Role of Medicare Advantage Plans as a Health Care Safety Net

More than 13 million Medicare beneficiaries – accounting for roughly 27 percent of all beneficiaries nationwide – currently are enrolled in Medicare Advantage plans and are receiving comprehensive, high quality, affordable coverage with benefits and innovative services that go well beyond the coverage offered by the Medicare fee-for-service (FFS) program. Survey findings¹ show that 88 percent of Medicare Advantage enrollees are satisfied with their coverage overall and 92 percent are satisfied with their doctor.

1. **MA Enrollees Receive Coordinated Care.** Seniors and people with disabilities are choosing Medicare Advantage plans because they have developed systems of coordinated care for ensuring that beneficiaries receive health care services on a timely basis, while also emphasizing prevention and providing access to disease management services for their chronic conditions. These coordinated care systems provide for the seamless delivery of health care services across the continuum of care. Physician services, hospital care, prescription drugs, and other health care services are integrated and delivered through an organized system whose overriding purpose is to prevent illness, improve health status, and employ best practices to swiftly treat medical conditions as they occur, rather than waiting until they have advanced to a more serious level.

Medicare Advantage plans also help to reduce emergency room visits for routine care, and ensure prompt access to primary care physicians and specialists when care is needed. In addition, they promote communication among treating physicians about the various treatments and medications a patient needs.

2. **Medicare Advantage Enrollees Have Strong Consumer Protections.** By law, coverage is guaranteed issue and Medicare Advantage plans offer coverage to all beneficiaries regardless of age or health status, although Special Needs Plans enroll only beneficiaries who meet criteria for the SNP type (e.g., dual eligibles, eligible for an institutional level of care, specified chronic conditions). All beneficiaries who choose a plan pay the same premium as all other plan enrollees. CMS performs annual reviews of Medicare Advantage plan benefit packages to ensure they are appropriate to beneficiaries with all health conditions. In

¹ Survey by Ayres, McHenry & Associates and the Feldman Group on behalf of AHIP, June 11-15, 2008

addition, nearly 90 percent of all Medicare Advantage enrollees are enrolled in Medicare Advantage plans that offer Part D prescription drug benefits, which allows beneficiaries to receive medical and prescription drug coverage from the same health plan – similar to how people receive coverage in the commercial market. Medicare Advantage plans typically redesign and reduce the cost sharing that applies under Medicare FFS. They may offer lower cost sharing as an additional benefit and typically eliminate deductibles and establish copayments rather than coinsurance.

Further, a Medicare Advantage enrollee who is not satisfied with a plan’s decision about providing or paying for covered services may exercise appeal rights through an internal plan appeals process, as well as automatic external review if the plan’s decision is not wholly in the beneficiary’s favor. Beneficiaries who choose to join Medicare Advantage plans also benefit from plan compliance with detailed requirements associated with CMS oversight activities that include operational and financial audits, evaluation of quality improvement projects, validation and evaluation of data on a broad spectrum of operational activities (e.g., customer service, resolution of appeals, and provider network adequacy), review and approval of plan marketing materials, and strong standards for the conduct of marketing activities.

3. **MA Enrollees Are Protected Against Unpredictable Out-of-Pocket Costs.** Medicare Advantage plans also protect beneficiaries from catastrophic health care costs. In 2012, all Medicare Advantage plans offer an out-of-pocket maximum limit for beneficiary costs, and about 78 percent of Medicare Advantage enrollees are in plans that have annual out-of-pocket maximums of \$5,000 or less, providing greater protection than the maximum \$6,700 cap that is required by law. These out-of-pocket maximums – which are not offered by the Medicare FFS program – help protect Medicare beneficiaries from catastrophic health care expenses that otherwise might pose a serious threat to their financial security.

Medicare Advantage plans also help reduce out-of-pocket costs for enrollees by reducing premiums for Part B and Part D, and by limiting cost-sharing for Medicare-covered services, including primary care physician visits and inpatient hospital stays.

4. **MA Enrollees Receive Additional Services.** Medicare Advantage plans offer a range of additional services that build upon the coordination of care, consumer protections, and protection against high out-of-pocket costs that are available to their enrollees. These

features of the program, combined with the innovative services offered by plans, are integral to improving the efficiency and effectiveness of health care for beneficiaries. The following are additional specific examples of the extra benefits and services that are not included in the Medicare FFS program, but are offered by Medicare Advantage plans to improve enrollees' coverage and manage their overall health and well-being on an ongoing basis:

- Case management services
- Disease management programs
- Coordinated care programs
- Prescription drug management tools integrated with medical benefits
- Tools and data collection to address disparities in care for racial and ethnic minorities
- Nurse help hotlines
- Enhanced coverage of home infusion, personal care and durable medical equipment
- Personal health records to offer beneficiaries greater control over their health information and to coordinate information better
- Vision, hearing, and dental benefits coordinated with medical services

5. **Peer Reviewed Studies Show the Value of Medicare Advantage.** As a direct result of these additional benefits and services, peer reviewed research has demonstrated that Medicare Advantage plans are more effective than the Medicare FFS program at addressing crucial patient care issues facing the nation, including reducing preventable hospital readmissions, increasing primary care visits, and managing chronic illnesses. The following are several examples:

One recent study published in the *American Journal of Managed Care* (AJMC) found that the Medicare Advantage readmission rate was about 13 percent to 20 percent lower than that in the Medicare FFS program.² In addition, a study published in the January 2012 edition of *Health Affairs* found that beneficiaries with diabetes in a Medicare Advantage special needs plan (SNP) had “seven percent more primary care physician office visits; nine percent lower

² Lemieux, Jeff, MA; Cary Sennett, MD; Ray Wang, MS; Teresa Mulligan, MHSA; and Jon Bumbaugh, MA. “Hospital Readmission Rates in Medicare Advantage Plans.” *American Journal of Managed Care*. February 2012. Vol. 18, no. 2, p. 96-104. This study was preceded by a series of working papers and reports published by AHIP’s Center for Policy and Research. One earlier study based on an analysis of hospital discharge datasets in five states estimated that risk-adjusted 30-day readmissions per patient with an admission ranged from 12-27 percent lower in Medicare Advantage than in Medicare FFS among patients with at least one admission. See: <http://www.ahip.org/Hospital-Readmissions/>

hospital admission rates; 19 percent fewer hospital days; and 28 percent fewer hospital readmissions compared to patients in FFS Medicare.”³

Additional research co-authored by researchers affiliated with The Brookings Institution concluded that Medicare Advantage plans outperformed the Medicare FFS program in 9 out of 11 clinical quality measures.⁴ This means that Medicare Advantage enrollees received the level of effective care recommended by a doctor with greater frequency than patients in Medicare FFS, for 9 of the 11 procedures studied. These findings confirm that Medicare Advantage plans deliver effective and consistent care for a number of important procedures at higher rates compared to the Medicare FFS program. This added value is a factor in improving the health and well-being of Medicare Advantage enrollees – especially those with high-risk conditions, such as diabetes, heart disease, breast cancer, and depression.

Another recent study, conducted by researchers at the HHS Agency for Healthcare Research and Quality (AHRQ) and the Research Triangle Institute (RTI) and published by the *Medicare and Medicaid Research Review* (a CMS journal), demonstrates the positive impacts of Medicare Advantage compared to the Medicare FFS program in terms of improving quality primary care by reducing preventable hospital admissions.⁵ The three states examined in this study (New York, California, and Florida) were chosen due to historically high rates of Medicare managed care enrollment. Researchers used 2004 hospital discharge data from the Healthcare Cost and Utilization Project (HCUP). This year was chosen because HMOs were most prevalent in the market at that time, providing an opportune time to test the impact of Medicare Advantage on preventable hospitalizations. The study found that preventable admissions, relative to the control group, were lower for Medicare Advantage enrollees than Medicare FFS enrollees in all three states. The study concluded that “MA plans have added value to the quality of primary care for the elderly by reducing preventable hospitalizations.”

³ Cohen, Robb, Jeff Lemieux, Jeff Schoenborn, and Teresa Mulligan. “Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients.” *Health Affairs*. January 2012. Vol. 31, no. 1, p. 110-119.

⁴Brennan, Niall MPP & Shepard, Mark BA. *Comparing Quality of Care in the Medicare Program*. The American Journal of Managed Care, November 2010.Vol. 16 No. 11, p. 841-848.(www.ajmc.com)

⁵ Medicare Managed Care Plan Performance: A Comparison across Hospitalization Type. Jayasree Basu & Lee Rivers Mobley. Medicare & Medicaid Research Review, 2012: Volume 2, Number 1

The value of Medicare Advantage is further demonstrated by another study⁶, also conducted by an AHRQ researcher, showing that enrollment in Medicare Advantage plans was associated with significant reductions in racial and ethnic differences in preventable hospitalization rates and improved quality primary care. Since access to quality primary care can help avoid preventable hospitalizations, this finding suggests that Medicare Advantage plans may improve the quality of primary care and reduce current disparities in this area of health care.

Leaders in the policy and scientific communities have clearly indicated that meeting these challenges is the key to improving the efficiency and effectiveness of the health care system. Private health plans already have a strong track record in these areas and are continuing to advance these reforms in the Medicare Advantage program and throughout the broader health care system.

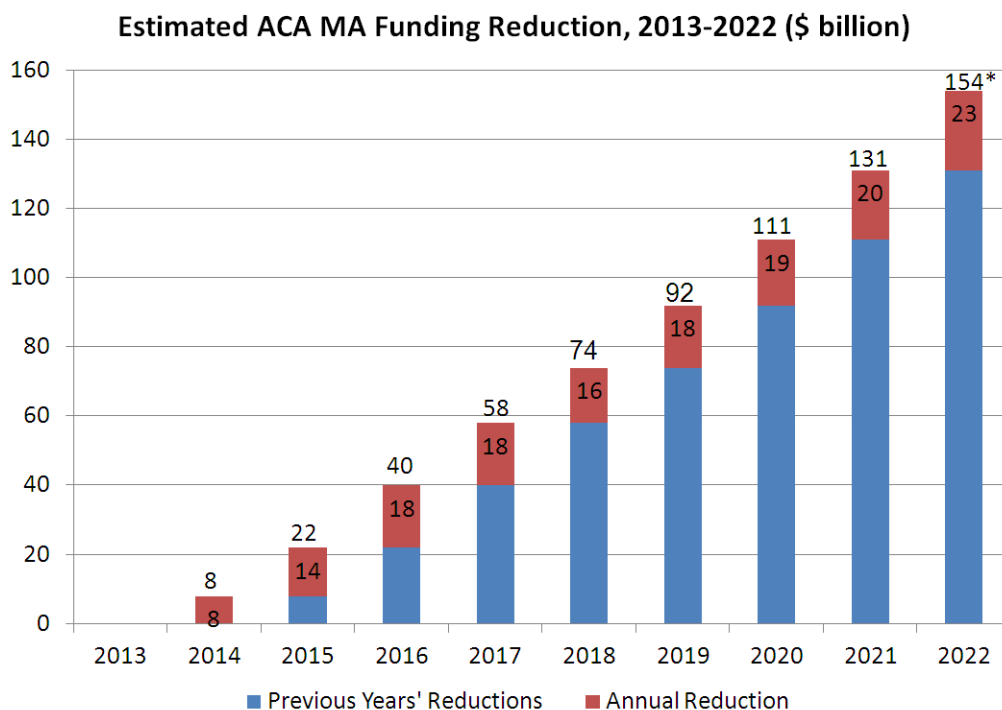
IV. Assessing the Impact of Future ACA Cuts on Medicare Advantage Enrollees

Plan sponsors are doing everything they can to offer coverage options that meet the needs of Medicare beneficiaries. The good news in recent days about the continued availability of high quality, affordable health plan choices in the Medicare Advantage program demonstrates that our members have been successful in delivering value to the beneficiaries they serve through systems of coordinated care and innovative services that improve the efficiency and effectiveness of health care. Looking forward, however, we continue to be concerned about the impact of the ACA's future cuts on Medicare Advantage enrollees, as well as the premium tax that begins in 2014.

⁶ Jayaree Basu. "Medicare managed care and primary care quality: Examining racial/ethnic effects across states." Health Care Management Science. September 2011

Cuts in Medicare Advantage Funding

According to the 2010 estimates from the Congressional Budget Office (CBO)⁷, the ACA will reduce funding for the benefits of Medicare Advantage enrollees by more than \$200 billion over ten years (2010-2019). CBO estimated that the law will *directly* reduce funding for the Medicare Advantage program by an estimated \$136 billion in this timeframe. CBO further estimated that, because of the linkage between Medicare Advantage payment benchmarks and Medicare FFS spending, the ACA's other Medicare FFS reimbursement changes will *indirectly* reduce funding for Medicare Advantage by an additional \$70 billion over ten years. More recently, in July of this year, CBO issued revised estimates⁸ indicating that the ACA would *directly* reduce Medicare Advantage funding by \$156 billion in the current ten-year budget window (2013-2022). This estimate did not include information on the ACA's *indirect* cuts to the Medicare Advantage program.



Source: CBO Letter to the Honorable John Boehner (July 24, 2012)

*NOTE – Rounding Effect: CBO reports total 10-yr funding cut = \$156 billion

⁷ CBO, Selected CBO Publications Related to Health Care Legislation (2009-2010), December 2010, pages 29-34

⁸ CBO, Letter to House Speaker John Boehner, July 24, 2012

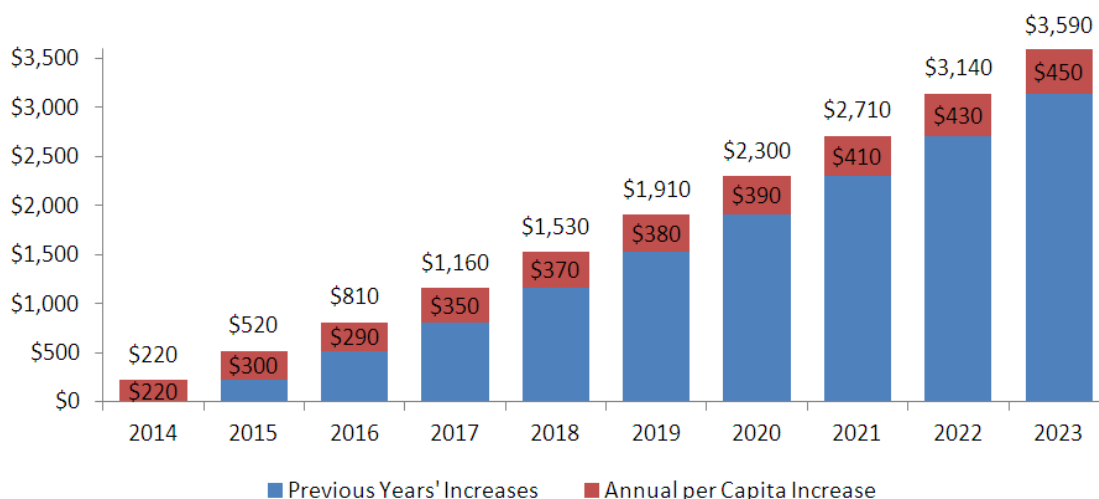
Given the scope and scale of these funding cuts, we have serious concerns about their likely impact. Because the vast majority of the ACA's cuts to the Medicare Advantage program have not yet taken effect, beneficiaries have not yet felt their full impact. This impact will be heightened by a new premium tax scheduled to begin in 2014.

Premium Tax on MA and Part D Programs

Medicare Advantage enrollees also will be impacted by the new health insurance premium tax established by the ACA. An actuarial study⁹ by the Oliver Wyman firm, commissioned by AHIP, found that the new premium tax is likely to increase costs – through higher premiums or higher cost-sharing – for beneficiaries enrolled in Medicare Advantage plans and Medicare Part D prescription drug plans.

According to the Oliver Wyman study, Medicare Advantage plans will pay \$220 per member in 2014 and \$450 per member in 2023 as a result of this tax, for a total tax burden of \$3,590 per member over ten years. For Medicare Part D plans, the tax will increase premiums by an estimated \$9 in 2014 and \$20 in 2023, for a total increase of \$161 over 10 years.

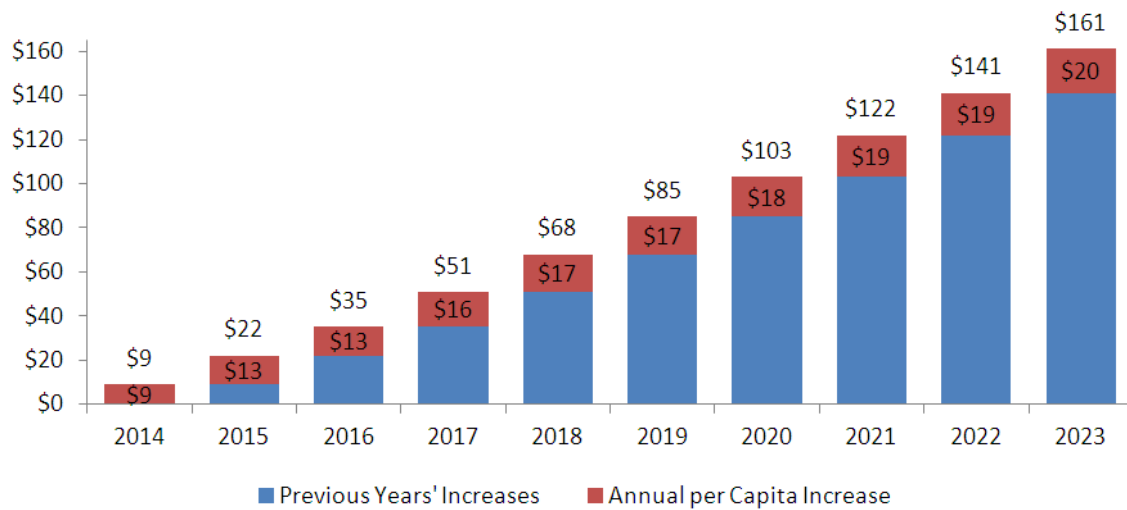
Cost Increase for Medicare Advantage Enrollees Due to ACA Premium Tax



Source: Oliver Wyman study, October 2011

⁹ Carlson, Chris. "Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans." Oliver Wyman. 31 October 2011.

Cost Increase for Medicare Part D Enrollees Due to ACA Premium Tax



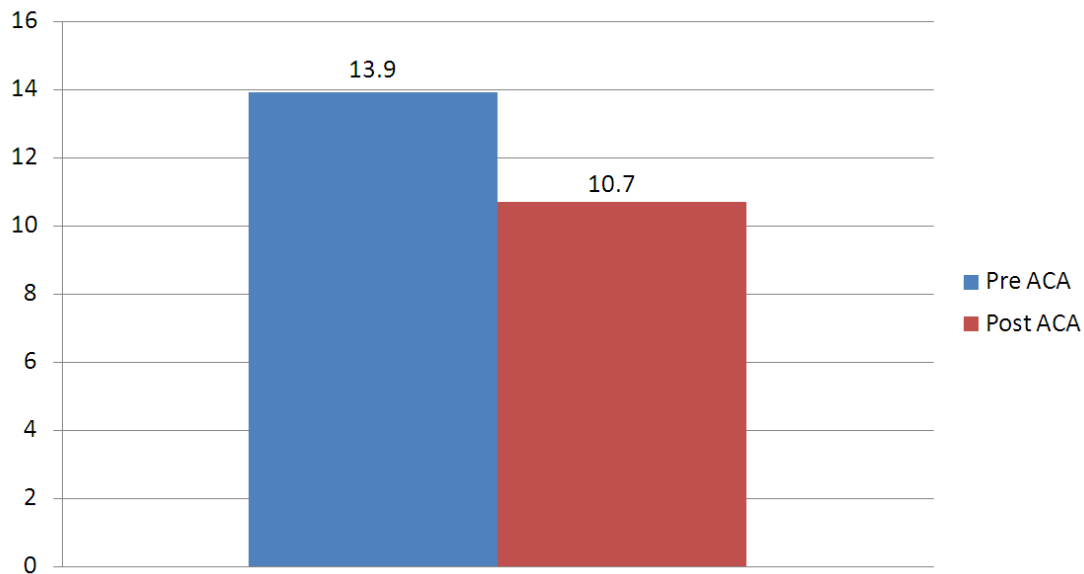
Source: Oliver Wyman study, October 2011

In addition to the ACA's Medicare Advantage funding cuts and the new premium tax, another serious concern is that across-the-board sequestration cuts, triggered under the Budget Control Act of 2011, would further limit the resources available to support the benefits of Medicare Advantage enrollees. These additional cuts – if they are implemented – could further disrupt coverage for Medicare Advantage beneficiaries and place a financial burden on providers participating in the program.

Enrollment Impact

The ACA's likely impact on the Medicare Advantage program is highlighted by CBO projections showing that the ACA will adversely impact enrollment in the Medicare Advantage program. In its March 2012 baseline, CBO projected that the ACA's funding cuts will cause Medicare Advantage enrollment to decline to 10.7 million in 2019. This decline represents a 23 percent reduction from the pre-ACA enrollment level of 13.9 million that was anticipated for 2019 according to CBO estimates issued in 2010.

2019 MA Enrollment Estimates, Pre and Post ACA (millions)



Sources: Pre-ACA estimate: CBO, Selected CBO Publications Related to Health Care Legislation (2009-2010), December 2010
Post-ACA estimate: CBO, March 2012 Baseline

Impact on Vulnerable Beneficiaries

In evaluating the impact of the ACA's funding cuts, it is important to recognize the crucial role the Medicare Advantage program plays as a health care safety net for many low-income beneficiaries and other vulnerable populations.

For years, AHIP has been tracking government data that show how valuable Medicare Advantage plans are for vulnerable beneficiaries, particularly those who are not eligible for Medicaid and do not have employer-sponsored retiree benefits. For many of these individuals, Medicare Advantage may be their only option for comprehensive, affordable coverage.

Key findings of our most recent analysis¹⁰, based on 2010 data and published in May 2012, show that:

¹⁰ AHIP Center for Policy and Research, Low-Income & Minority Beneficiaries in Medicare Advantage Plans, May 2012

- Thirty-nine percent of all Medicare beneficiaries had incomes below \$20,000. By comparison, 43 percent of Medicare Advantage enrollees had incomes below \$20,000.
- Sixty-four percent of African-American Medicare Advantage enrollees and 82 percent of Hispanic Medicare Advantage enrollees had incomes below \$20,000.

These findings demonstrate that Medicare Advantage plans are important to many beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare FFS program. These vulnerable beneficiaries will pay a heavy price if the ACA's Medicare Advantage funding cuts are fully implemented.

Recent data clearly demonstrate that Medicare Advantage plans will continue to do their best to mitigate the impact of these funding cuts in the future. However, past history¹¹ suggests it is likely that the continued erosion of Medicare Advantage funding eventually would lead to increased costs for beneficiaries and reduced access to health plans that are demonstrating better performance on quality than Medicare FFS. We look forward to working with the Committee to mitigating the impact of these future cuts on beneficiaries.

V. Reauthorization of Medicare Advantage Special Needs Plans

Medicare Advantage Special Needs Plans (SNPs) have played an important role in meeting the health care needs of Medicare beneficiaries. SNPs serve as a crucial safety net for approximately 1.5 million of our nation's most vulnerable seniors, many of whom have disabilities and chronic conditions. Enrollees in SNPs benefit from the coordinated care, disease management, and other initiatives our members have pioneered to ensure that they receive high quality health care across the entire continuum of services they need.

SNPs were authorized by the Medicare Modernization Act of 2003 to provide new coverage options to beneficiaries with specific health care challenges. Three categories of SNPs are authorized under current law: (1) Dual Eligible SNPs serve beneficiaries who are dually eligible for both Medicare and Medicaid; (2) Chronic Care SNPs serve beneficiaries with severe or disabling chronic conditions; and (3) Institutional SNPs serve beneficiaries who live in skilled

¹¹ According to an analysis of CMS data from 1999 to 2003, after enactment of the Balanced Budget Act of 1997, nearly 2.4 million Medicare beneficiaries were affected by plan withdrawals and benefit reductions.

nursing facilities or other long-term care institutions or who qualify for an institutional level of care and live in the community. All three types of SNPs tailor their benefits and services to address the unique needs of the specific populations they serve, and a number of studies indicate that SNPs are providing a high level of value to both beneficiaries and taxpayers.

- **Dual Eligible SNPs:** Dual Eligible SNPs are at the forefront of providing cost effective, quality care to vulnerable populations. Several studies¹² have documented their success in achieving cost savings for state Medicaid programs by reducing inpatient hospital admissions and institutionalization for their dually eligible members while providing patient-centered, coordinated care. By targeting programs to meet the distinct needs of special populations of beneficiaries, Dual Eligible SNPs are demonstrating that they provide high quality care to beneficiaries with unique needs.
- **Chronic Care SNPs:** Nearly 25 percent of Medicare beneficiaries have five or more chronic conditions and account for 68 percent of Medicare spending.¹³ Tailored programs that address these conditions better coordinate and manage care and may improve quality of life and reduce long-term costs for the Medicare program by preventing unnecessary hospitalizations. Examples of activities typically undertaken by Chronic Care SNPs include engaging care coordinators with expertise in the specific condition addressed by the plan, developing provider networks that specialize in the condition targeted by the plan, and providing extended drug coverage through the Part D coverage gap for medications important to treating the condition that is the focus of the SNP.
- **Institutional SNPs:** Beneficiaries who qualify for an institutional level of care can particularly benefit from the special attention that Institutional SNPs can provide. These plans typically link beneficiaries with care coordinators – generally nurse practitioners – who manage teams of health care providers to ensure that the needs of beneficiaries are being met. These teams also include social workers, behavioral health specialists, and pharmacists who educate beneficiaries about their conditions, monitor health status, and identify health care and other needs. Independent studies have demonstrated that the model of care used by Institutional SNPs improves health outcomes. A 2003 University of Minnesota study found that enrollees in an Institutional SNP experienced fewer hospitalizations, reduced emergency department visits, and decreased hospital length of stay in comparison to other nursing home patients.¹⁴

¹² See for example “MassHealth Senior Care Options Program Evaluation: Pre-SCO Enrollment Period CY 2004 and Post-SCO Enrollment Period CY 2005 Nursing Home Entry Rate and Frailty Level Comparisons,” JEN Associates Incorporated and The Lewin Group, “Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities.” (November 2008)

¹³ Anderson, G.F., “Medicare and Chronic Conditions”, New England Journal of Medicine, Vol. 353(3):305-309, 2005.

¹⁴ Kane, RL et al. “The Effect of Evercare on Hospital Use.” *Journal of American Geriatrics Society*, 2003;51(10):1247-1434

Under current law, the authorization for SNPs ends on December 31, 2013. It is important for Congress to take action promptly to reauthorize this program to ensure that SNP enrollees can continue to benefit from plans tailored to address their unique needs. Moreover, a longer term reauthorization covering several years is crucial to ensuring that SNP enrollees who benefit most from these plans have the peace of mind in knowing that they will continue to have access to them.

VI. Conclusion

Thank you again for this opportunity to testify. Our members are strongly committed to working with Congress to strengthen the coverage options that are available to meet the health care needs of our nation's Medicare beneficiaries, and will continue to focus on developing innovative solutions and new tools and techniques to help sustain Medicare into the future.